August 31, 2018

Seema Verma,
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Verma:

The College of Healthcare Information Management Executives (CHIME) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule, "Medicare and Medicaid Programs: CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; etc.," published in the *Federal Register* on July 12th.

CHIME is an executive organization dedicated to serving chief information officers (CIOs), chief medical information officers (CMIOs), chief nursing information officers (CNIOs) and other senior healthcare IT leaders. With more than 2,700 members, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate the effective use of information management to improve the health and healthcare in the communities they serve.

CHIME recognizes the importance of an interconnected and interoperable healthcare system that strives to ensure patients are always at the center of their care. We support policies that support the use of digital technologies, including the agency's work to publish their data dictionary. We also understand that while strides continue to be made around both sharing information across the care continuum and fostering a truly interoperable healthcare system, that many limitations and

barriers remain. **We appreciate the opportunity to share our members' perspective around these issues and offer the following high-level comments:**

1. **Support for CMS' work around the data dictionary;**
2. **Agree with the remote health monitoring proposal, though we recommend CMS establish a common definition of "remote patient monitoring" across its programs; and**
3. **Stronger collaboration among long-term and post-acute care providers, acute hospitals, electronic health vendors (EHR) and CMS can foster to improve transitions of care and avert readmissions through better data exchange, particularly if the focus is on medication reconciliation. We urge CMS to convene these stakeholders together relying first on collaboration prior to issuing any new data exchange requirements.**

Remote Health Monitoring

Covering Administrative Costs

Section 4012 of the 21st Century Cures Act directed CMS to provide information on the current use of and/or barriers to telehealth services. CHIME is extremely supportive of policies which continue to encourage the use of telehealth services as we believe this can improve access to care and improve patient outcomes. And, we agree with CMS that "the growth of technology and new software development could be used in the provision of care and care coordination in the home, as well as empower patients to be active participants in their disease management."

Telehealth services can be used to substitute for professional in-person visits when certain eligibility criteria are met. However, payment for these services is very limited. CMS is prohibited from paying for home health services delivered via a telecommunications system if such services substitute for in-person home health services ordered as part of a plan of care certified by a physician. But, as CMS notes, the law does not define the term "telecommunications system" as it relates to the provision of home health care and explicitly notes that an HHA is not prevented from providing services via a telecommunications system, assuming the service is not considered a home health visit for purposes of eligibility or payment.

In considering these limitations, CMS has proposed that remote patient monitoring, while a service using a form of telecommunications, is not considered a Medicare telehealth service as defined under section 1834(m) of the Social Security Act, which places a series of restrictions around how Medicare may reimburse for telehealth. Therefore, CMS has called for allowing the use of "digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations" since they don't consider this to be telehealth. We support this alternative definition, which may provide support for encouraging further use of these important technologies.

CMS is proposing to reimburse for the costs of remote patient monitoring as an allowable administrative cost. CHIME agrees with CMS that, "remote patient monitoring could be beneficial in augmenting the home health services outlined in the patient's plan of care, without replicating or replacing home health visits," and we support CMS' proposal.

Further, we believe that CMS should ensure a common definition of "remote patient monitoring" across its beneficiary programs (e.g., consistency with technical codes 990X0 and 990X1). We

therefore urge CMS to shift away from its definition proposed in the draft rule, and to align its definition of remote patient monitoring with that proposed for 990X0 and 990X1.

These new codes do a better job of accurately reflecting timeliness and clinical competency allowed for the service. The new CPT 994X9 allows RPM services to be performed by clinical staff. However, CMS needs to change how the CPT 994X9 for RPM services are to be performed and billed as "incident to" under general versus direct supervision of the billing physician. Most RPM services are effectively delivered under general supervision, which does not require a physician to be present in the same building at the same time. The telemedicine technology used for real time virtual consults should provide the "incident to" level of general supervision and physician direction necessary for interactive communication with the patient. We feel this clarification is necessary for the final rule to support the success of these new codes and definition of "remote patient monitoring".

While we support the provisions outlined above, we encourage CMS to explore options for paying for this valuable service and the provision of synchronous telehealth visits, beyond just costs for equipment, especially since this service may require additional training, support systems and skilled employees.

Infusion Home Therapy

Home infusion therapy is a treatment option for patients with a wide range of acute and chronic conditions, ranging from bacterial infections to more complex conditions such as late-stage heart failure and immune deficiencies.

Section 5012 of the 21st Century Cures Act established a new Medicare home infusion therapy benefit. The Medicare home infusion therapy benefit covers the professional services, including nursing services, furnished in accordance with the plan of care, patient training and education (not otherwise covered under the durable medical equipment benefit), remote monitoring, and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. Although the cost of remote patient monitoring is not separately billable and can't be used as a substitute for in-person home health services, as CMS notes there is nothing to preclude home health agencies from using remote patient monitoring to augment the care planning process as appropriate. CHIME supports CMS' proposal to begin reimbursing for expenses of remote patient monitoring, if used by the HHA to augment the care planning process, by paying for this as an allowable administrative cost (operating expense) that is factored into the cost per visit.

Advancing Health Information Exchange

Data Element Library

Our members want to make sure that their vendors are collecting data that demonstrate value. Our members in the post-acute care space believe in the value of CMS' work to publish a data dictionary, a publicly available centralized, authoritative resource for standardized data elements and their associated mappings to health IT standards." We appreciate that once standards are available in the Data Element Library (DEL) they will not only be referenced on CMS' website but also in the Office of the National Coordinator for Health IT's (ONC) Interoperability Standards Advisory (ISA).

We believe this work will foster better uniformity and standardization, steps pivotal to advancing a standardized way to exchange data and foster better interoperability. We appreciate the

LOINC Code information for each data element and the alignment of “similar” questions across various assessment tools. In addition, we recognize the value of a good data governance process, which is very valuable in any organization. We look forward to expansion of the DEL to include data elements from assessment tools used in the acute and ambulatory environments.

To quote one of our members; this Data Element Library marks a “great step forward to have a single place to locate information – now it’s up to the post-acute to adopt.” Finally, we also agree with CMS that this has the potential to reduce provider burden.

Driving Greater Interoperability between Post-acute and Acute Providers

There are few issues that continue to vex our members, especially in the long-term post-acute care settings; one primary issue revolves around the free exchange of data with other providers in the care continuum, such as acute care providers. While the Data Element Library marks an important step forward, challenges remain:

1. **Standardized data:** How to standardize the bi-directional data to and from acute care/post-acute providers remains an outstanding concern.
2. **Different provider / patient needs:** Depending on the clinical condition, and even the setting a patient is being transitioned to, long-term and post-acute care providers may need different types of information. We encourage CMS continue to work on identifying and further outlining these needs.
3. **Timely access to data:** Receiving CCDs in a timely manner from acute care providers continues to present challenges regardless of whether the PAC Provider uses an HIE or whether they are receiving Direct Messages.
4. **Workflow /non-technology issues:** Many of the issues that delay the information transfer are related to workflow / communication issues and have nothing to do with technology that is used to exchange information. However, some issues are related to the ongoing challenge with bi-directional data flow.
5. **Costs:** High interface exchange fees coupled with per transaction fees often make data exchange cost prohibitive.

The challenge some of our members are running into as outlined above is that the information being sent is often delayed to the point of being rendered largely useless for high quality clinical care. Post-acute providers are receiving information 3-4 days after transfer when they need the information the day *of* the transfer, which can be the result of any number of process, workflow or technology challenges. This can result in an incomplete picture of the patient and duplicative lab work. For instance, one member explained that Requirements of Participation for a skilled nursing facility (SNF) might require a pneumonia vaccine within dictated timeframes. There are two different vaccines. Patients and families often do not know which vaccine was received and this may result in the patient receiving a duplicative vaccine.

Further, the data needed by one setting of care and by patient condition can vary and a one-size-fits-all approach with a single set of data will not solve the problem. That said, every setting would benefit from at least up to date information on what medications a patient is currently receiving, including “when” and “what” did the individual receive most recently. Adding further to these issues is the lack of standardization; many states have specific forms that must be completed as part of the transfer process from one setting, but there is no uniform way to communicate this data.

There appear to be a few reasons why data is either delayed, not being sent, or not being acted on. While much of the needed data is being sent by EHRs via fax and HIE, it isn't arriving in time for the receiving provider to act upon the information at admission. Part of this challenge is rooted in a concern that providers and their EHR vendor worry they may not be sending "all the information" or that the information may be incomplete. Another issue we hear is that clinicians do not trust the source of the data, whether that data comes from the post-acute, long-term care, acute or ambulatory settings. As another member reflected, "The attending and consulting doctors see the same patient and they don't read the others' notes. The problem is related to built-in workflows in the EHR because they don't trust the incoming data. That is still part of the hindrance – the culture – they are trying to get people to stop reordering tests but it's hard to stop doctors from doing it because they don't trust incoming data." And yet another related issue is that once the data does arrive, because workflows have not been established, providers don't know what to do with the data. We worry about policies that could levy penalties on providers who are not swapping information as this would be overly punitive and we do not expect this will drive better connectivity or interoperability.

In CMS' final rule for skilled nursing facilities, the agency requires these providers to obtain certain information from acute hospitals. We appreciate that the Administration is looking beyond regulation to spur interoperability such as with the voluntary Trusted Exchange Framework in development by ONC. It is worth noting that information flowing in both directions (between acute and post-acute / long-term care) is really needed to foster better patient care and there is as much need for the acute-care setting to get information from the post-acute / long-term care settings when a patient is transferred as there is when a patient is being discharged from a hospital. We believe there is an opportunity for the post-acute / long-term care community, the acute care community and CMS to work collaboratively together to help patients avoid costly readmissions. One of the biggest ways we think this can be successful is with a greater emphasis around medication reconciliation. As one member described a common scenario, "patients show up in the SNF with a paper bag with meds and they need to figure out what should be continued." We do not, however, believe that a regulatory mandate or "stick" is the right approach to tackling these issues. We believe a better approach is for all parties to work collaboratively. The lack of EHR incentives for the long-term care and post-acute care providers, who were not included in the Health Information Technology for Economic and Clinical Health (HITECH) Act incentive program, has created challenges that we believe could better be resolved by working together to systematically address each concern and put the patient at the center of their care. However, unless the issues outlined earlier around timely receipt of information are addressed, barriers will continue to exist, and technology alone will not address these underlying issues.

We also understand that CMS is considering two new measures for possible future inclusion in the Promoting Interoperability program aimed at better supporting interoperability. CMS has said they are considering adding these new measures in the future to better support long-term, post-acute care and behavioral health providers.

- **Health Information Exchange Across the Care Continuum:** If such a measure were adopted, CMS has said it would, for at least one transition of care or referral to a provider of care other than an eligible hospital or CAH, the eligible hospital or CAH creates a summary of care record using CEHRT; and electronically exchanges the summary of care record.

- **Support Electronic Referral Loops by Receiving and Incorporating Health Information Across the Care Continuum:** For at least one electronic summary of care record received by an eligible hospital or CAH from a transition of care or referral from a provider of care other than an eligible hospital or CAH, the eligible hospital or CAH conducts clinical information reconciliation for medications, mediation allergies, and problem list.

We appreciate that CMS is looking for ways to better support the care continuum, however, as indicated earlier, we believe the pathway to achieving this is one that should be rooted in collaboration and should address the five issues we outlined above: 1) standardized data; 2) varying provider and patient needs; 3) timely access to data; and 4) workflow / non-technology issues; and 5) costs. We worry that simply mandating another measure will not address the root cause issues. **We urge CMS to convene long-term providers, post-acute providers and EHR vendors to discuss how medication reconciliations can better be supported and how this can be achieved working together collaboratively.**

Conclusion

We appreciate the chance to comment on this important rule and the need to foster a healthy and vibrant system that uses technology to better care for patients. Should you have any questions please contact Mari Savickis, vice president, federal affairs at mari.savickis@chimecentral.org.

Sincerely,

Russell Branzell, FCHIME, CHCIO

CEO & President, CHIME